

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Daystar Care Center# 0032045 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 4/18/1990

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>83</u>	Skilled (SNF)	<u>83</u>	<u>30,295</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>83</u>	TOTALS	<u>83</u>	<u>30,295</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,501</u>	<u>913</u>	<u>3,361</u>	<u>5,775</u>	8
9	SNF/PED					9
10	ICF	<u>16,584</u>	<u>3,569</u>	<u>689</u>	<u>20,842</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,085</u>	<u>4,482</u>	<u>4,050</u>	<u>26,617</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 87.86%

D. How many bed-hold days during this year were paid by Public Aid?

1 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 07/22/1987

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 17 and days of care provided _____Medicare Intermediary IVANS

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 1/1 to 12/31/04 Fiscal Year: 1/1 to 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Daystar Care Center

0032045

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	159,280	9,142	3,764	172,186	(21,471)	150,715		150,715		1
2	Food Purchase		131,480		131,480	(16,308)	115,172		115,172		2
3	Housekeeping	90,453	15,298		105,751		105,751		105,751		3
4	Laundry	65,708	13,850		79,558		79,558		79,558		4
5	Heat and Other Utilities			117,130	117,130		117,130		117,130		5
6	Maintenance	48,933	14,417	19,350	82,700		82,700	(1,713)	80,987		6
7	Other (specify):*										7
8	TOTAL General Services	364,374	184,187	140,244	688,805	(37,779)	651,026	(1,713)	649,313		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	1,008,418	161,739	9,887	1,180,044		1,180,044		1,180,044		10
10a	Therapy	53,167	3,124	270,585	326,876		326,876		326,876		10a
11	Activities	63,860	880		64,740		64,740	(20)	64,720		11
12	Social Services	44,798	4,335	92	49,225		49,225		49,225		12
13	Nurse Aide Training										13
14	Program Transportation			5,708	5,708		5,708		5,708		14
15	Other (specify):*			4,150	4,150		4,150		4,150		15
16	TOTAL Health Care and Programs	1,170,243	170,078	294,022	1,634,343		1,634,343	(20)	1,634,323		16
	C. General Administration										
17	Administrative	44,843			44,843		44,843		44,843		17
18	Directors Fees										18
19	Professional Services			25,717	25,717		25,717		25,717		19
20	Dues, Fees, Subscriptions & Promotions			6,967	6,967		6,967	(663)	6,304		20
21	Clerical & General Office Expenses	106,049	11,199	13,478	130,726		130,726	(47)	130,679		21
22	Employee Benefits & Payroll Taxes			193,160	193,160	36,896	230,056	(7,499)	222,557		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,763	1,763		1,763		1,763		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			69,250	69,250		69,250		69,250		26
27	Other (specify):*					883	883	(883)			27
28	TOTAL General Administration	150,892	11,199	310,335	472,426	37,779	510,205	(9,092)	501,113		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,685,509	365,464	744,601	2,795,574		2,795,574	(10,825)	2,784,749		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Daystar Care Center

#0032045

Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			102,699	102,699		102,699		102,699			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,389	75,389		75,389	(3,128)	72,261			32
33	Real Estate Taxes			25	25		25	(25)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			178,113	178,113		178,113	(3,153)	174,960			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		5,870		5,870		5,870		5,870			41
42	Provider Participation Fee			34,114	34,114		34,114		34,114			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		5,870	34,114	39,984		39,984		39,984			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,685,509	371,334	956,828	3,013,671		3,013,671	(13,978)	2,999,693			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Daystar Care Center

0032045

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(883)	27		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,128)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(663)	20		28
29	Other-Attach Schedule	(8,578)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (13,252)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule	(726)	6	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (726)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (13,978)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Daystar Care Center

ID# 0032045

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Flowers	\$ (47)	21	1
2	Non-Allowable Real Estate Tax	(25)	33	2
3	Transportation Reimbursement	(987)	6	3
4	Activity Department Revenue	(20)	11	4
5	Meal Income	(7,499)	22	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(8,578)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Daystar Care Center

0032045

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,713)	0	0	0	0	0	0	0	0	0	0	(1,713)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,713)	0	0	0	0	0	0	0	0	0	0	(1,713)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(20)	0	0	0	0	0	0	0	0	0	0	(20)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(20)	0	0	0	0	0	0	0	0	0	0	(20)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(663)	0	0	0	0	0	0	0	0	0	0	(663)	20
21	Clerical & General Office Expenses	(47)	0	0	0	0	0	0	0	0	0	0	(47)	21
22	Employee Benefits & Payroll Taxes	(7,499)	0	0	0	0	0	0	0	0	0	0	(7,499)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(883)	0	0	0	0	0	0	0	0	0	0	(883)	27
28	TOTAL General Administration	(9,092)	0	0	0	0	0	0	0	0	0	0	(9,092)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(10,825)	0	0	0	0	0	0	0	0	0	0	(10,825)	29

Summary B

12/31/2004

12/31/2004

[illegible]

Facility Name & ID Number Daystar Care Center

0032045

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Daystar Care Center # 0032045 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Daystar Care Center# 0032045 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	USDA, Rural Development		x	Construct Building	\$15,515.00	9/23/91	\$ 2,217,773	\$ 895,303	9/23/17	7.0000	\$ 67,222	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Capaha Bank		x	Line of Credit		various	24,942	148,188	2/22/05	6.7500	7,934	6	
7	Interest Income										(3,128)	7	
8												8	
9	TOTAL Facility Related				\$15,515.00		\$ 2,242,715	\$ 1,043,491			\$ 72,028	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,242,715	\$ 1,043,491			\$ 72,028	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Daystar Care Center

0032045 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$ 25	2
3. Under or (over) accrual (line 2 minus line 1).				\$ 25	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$ 25	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1999	17	8
	2000	19	9
	2001	20	10
	2002	21	11
	2003	22	12

FOR OHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Daystar Care Center COUNTY Alexander

FACILITY IDPH LICENSE NUMBER 0032045

CONTACT PERSON REGARDING THIS REPORT Amy Keistler

TELEPHONE 618-734-1700 FAX #: 618-734-2611

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>2383</u>	<u>Lot 1 Kobler's Addition</u>	\$ <u>25.00</u>	\$ <u>25.00</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>25.00</u>	\$ <u>25.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 26,356

B. General Construction Type:
 Exterior
 Wood
 Frame
 Wood
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building Site	139,264	10/12/1995	\$ 27,200	1
2	Vacant	3,513	8/1/1997	200	2
3	TOTALS	142,777		\$ 27,400	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Daystar Care Center

0032045

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	83		1987	1987	\$ 1,148,065	\$ 38,269	30	\$ 38,269	\$	\$ 666,515	4
5			1991	1991	(10,658)	(402)	26.5	(402)		(5,575)	5
6			1994	1994	3,500	152	23	152		1,674	6
7											7
8											8
	Improvement Type**										
9	Heating System		1987	1987	160,880	8,044	20	8,044		140,100	9
10	Piping & Plumbing		1987	1987	176,139	7,045	15	7,045		122,710	10
11	Ventilation Fans		1987	1987	8,120		20			8,120	11
12	Fixtures		1987	1987	45,875	2,294	20	2,294		39,950	12
13	Sprinkler System		1987	1987	41,220	1,649	25	1,649		28,717	13
14	Wiring		1987	1987	170,162	8,508	20	8,508		148,183	14
15	Diesel Generator		1987	1987	25,254	1,263	20	1,263		21,992	15
16	Fire Alarm System		1987	1987	12,529	626	10	626		10,911	16
17	Paging, Alarm and TV		1987	1987	19,705		15			19,705	17
18	Sign		1987	1987	2,554		12			2,554	18
19	Landscaping		1987	1987	7,500		10			7,500	19
20	Walks, Patio, and Curbs		1987	1987	15,709	785	20	785		13,680	20
21	Telephone System		1987	1987	12,889	644	20	644		11,224	21
22	Patio		1988	1988	16,738	837	20	837		13,530	22
23	Storage Shed		1988	1988	2,054	103	20	103		1,721	23
24	Air Condition Window Unit		1990	1990	953		8			953	24
25	Patio		1991	1991	2,611	130	20	130		1,730	25
26	Magic Air Handling Unit		1991	1991	2,241		10			2,241	26
27	Telephone System		1991	1991	1,583		10			1,583	27
28	Gazebo		1992	1992	3,575	179	20	179		2,159	28
29	Gazebo Landscaping		1992	1992	1,180		10			1,180	29
30	Heating and Air Conditioning Unit		1992	1992	1,839	123	15	123		1,512	30
31	Awning for Building		1993	1993	2,500		10			2,500	31
32	Water Heater		1995	1995	4,032	493	15	493		2,531	32
33	Entry Access System		1996	1996	2,883	288	10	288		2,379	33
34	Boiler Shell		1996	1996	2,525	253	10	253		2,083	34
35	Parking Lot Blacktop		1997	1997	8,400	420	20	420		3,290	35
36	A/C Conditioner Condensers (2)		1998	1998	3,386	339	10	339		2,257	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Quarry Tile Floor	2000	\$ 14,041	\$ 936	15	\$ 936		\$ 4,524		37
38	Surveillance System	2000	1,846	369	5	369		1,723		38
39	Door to Boiler Room	2000	504	72	7	72		336		39
40	Camera System - Alzheimer's Unit	2000	1,200	171	7	171		757		40
41	Compressor	2001	2,375	238	10	238		871		41
42	Hot Water Heater	2001	6,199	413	15	413		1,343		42
43	Alzheimer's Unit	2002	80,070	2,002	40	2,002		4,504		43
44	Water Heater	2004	8,398	466	15	466		466		44
45	Roof	2004	44,350	370	20	370		369		45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,054,926	\$ 77,079		\$ 77,079		\$ 1,294,502		70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 222,371	\$ 17,965	\$ 17,965	\$		\$ 167,183	71
72	Current Year Purchases	47,269	1,474	1,474			1,474	72
73	Fully Depreciated Assets	194,548					194,548	73
74								74
75	TOTALS	\$ 464,188	\$ 19,439	\$ 19,439	\$		\$ 363,205	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2000 Dodge	2001	\$ 30,903	\$ 6,181	\$ 6,181	\$	5	\$ 24,207	76
77										77
78										78
79										79
80	TOTALS			\$ 30,903	\$ 6,181	\$ 6,181	\$		\$ 24,207	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,577,417	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,699	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 102,699	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,681,914	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12	Other (specify):									13
13										
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 110,896	\$	1
2	Cash-Patient Deposits	14,857		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	634,794		3
4	Supply Inventory (priced at)	6,019		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,757		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 784,323	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,400		13
14	Buildings, at Historical Cost	2,051,539		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	498,478		16
17	Accumulated Depreciation (book methods)	(1,681,914)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	192,445		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,087,948	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,872,271	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 376,770	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,857		28
29	Short-Term Notes Payable	148,188		29
30	Accrued Salaries Payable	55,862		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	4,979		33
34	Deferred Compensation	37,969		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Misc. Employee Withholdings	22,059		36
37	Current Portion Long-Term Debt	127,549		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 788,233	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	767,754		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 767,754	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,555,987	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 316,284	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,872,271	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 250,725	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 250,725	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	65,559	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 65,559	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 316,284	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,997,596	1
2	Discounts and Allowances for all Levels	(23,642)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,973,954	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	10,650	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,944	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,594	23
D. Non-Operating Revenue			
24	Contributions	77,255	24
25	Interest and Other Investment Income***	3,128	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 80,383	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Patient Transportation	6,279	28
28a	Activity Department	20	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,299	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,079,230	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	688,805	31
32	Health Care	1,634,343	32
33	General Administration	472,426	33
B. Capital Expense			
34	Ownership	178,113	34
C. Ancillary Expense			
35	Special Cost Centers	39,984	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,013,671	40
41	Income before Income Taxes (line 30 minus line 40)**	65,559	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 65,559	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Daystar Care Center

0032045

Report Period Beginning: 01/01/2004

Ending:

12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,431	1,635	\$ 37,950	\$ 23.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,389	7,769	139,245	17.92	3
4	Licensed Practical Nurses	15,052	16,343	248,108	15.18	4
5	Nurse Aides & Orderlies	62,024	66,371	545,512	8.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,719	6,217	53,167	8.55	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,736	2,000	22,155	11.08	9
10	Activity Assistants	4,258	4,699	41,704	8.88	10
11	Social Service Workers	3,503	3,882	44,798	11.54	11
12	Dietician					12
13	Food Service Supervisor	1,729	1,895	21,151	11.16	13
14	Head Cook	1,940	1,898	18,387	9.69	14
15	Cook Helpers/Assistants	13,856	15,235	119,741	7.86	15
16	Dishwashers					16
17	Maintenance Workers	3,533	3,842	48,933	12.74	17
18	Housekeepers	10,146	10,932	90,453	8.27	18
19	Laundry	7,141	7,943	65,708	8.27	19
20	Administrator	1,928	2,148	45,672	21.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,629	9,168	105,220	11.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,371	3,667	37,605	10.25	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	153,385	165,644	\$ 1,685,509 *	\$ 10.18	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	86	\$ 3,764	1-3	35
36	Medical Director	120	3,600	9-3	36
37	Medical Records Consultant	35	1,597	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	550	15-3	39
40	Physical Therapy Consultant	6,600	270,585	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	79	4,335	12-3	45
46	Other(specify) Doctor	120	3,600	15-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	7,051	\$ 288,031		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Amy Keistler			\$ 44,843	Workers' Compensation Insurance		\$ 54,464	IDPH License Fee		\$		
				Unemployment Compensation Insurance		10,316	Advertising: Employee Recruitment		72		
				FICA Taxes		127,942	Health Care Worker Background Check (Indicate # of checks performed _____)				
				Employee Health Insurance			Advertising		1,223		
				Employee Meals		37,779	Dues and Subscriptions		5,672		
				Illinois Municipal Retirement Fund (IMRF)*							
				Other Employee Benefits							
				Meal Income		(7,944)					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$	44,843		Less: Public Relations Expense		(
B. Administrative - Other							Non-allowable advertising		(
Description				Amount			Yellow page advertising		(663)		
			\$				TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,304		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$		TOTAL (agree to Schedule V, line 22, col.8)		\$	222,557		
C. Professional Services						E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Keane Computer Care	Computer Maintenance		\$ 4,582			\$	Out-of-State Travel		\$		
Mark Johnson	Legal Fees		925				Withing 50 miles for patient care		586		
BHRSS, LLC	Audit		5,000				In-State Travel		776		
BHRSS, LLC	Monthly Review Service		2,100								
BHRSS, LLC	Cost Report		4,775				Seminar Expense		401		
IVAN's	Medicare Billing		1,050								
Earthlink	Internet Services		264								
CPU, Inc	Monthly Financial StmtS		2,135								
C&S Consulting	Computer Tech Support		3,551				Entertainment Expense		(
Administar	Medicare		25				(agree to Sch. V, line 24, col. 8)				
Wessels & Pautsch, PC	Legal Fees		400				TOTAL		\$ 1,763		
Accu-Med	Computer Tech Support		910								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$	25,717	TOTAL		\$			

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Repair Tile - Bathroom	10-94	\$ 5,910	10	\$ 591	\$ 591	\$ 591	\$ 493	\$	\$	\$	\$	\$
2	Repair - Generator	2-96	2,325	10	233	233	233	233	233	15			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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17													
18													
19													
20	TOTALS		\$ 8,235		\$ 824	\$ 824	\$ 824	\$ 726	\$ 233	\$ 15	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Daystar Care Center

STATE OF ILLINOIS

0032045

Report Period Beginning: 01/01/2004

Page 23

Ending: 12/31/2004

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Ill Assoc. of Homes for the Aging
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 34,114
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. _____

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 36,896 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,944
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 6,279
c. What percent of all travel expense relates to transportation of nurses and patients? 77%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? None
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Beussink, Hey, Roe, Seabaugh & Stroder, L.L.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? None
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? n/a
Attach invoices and a summary of services for all architect and appraisal fees.